No. 04-1367

In The
Supreme Court of the United States

KENIA MARITZA CINTRÓN PARRILLA, ET AL,

Pro Se Petitioners,

v.

ELI LILLY INDUSTRIES, INC., ET AL,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The First Circuit

PETITIONERS' REPLY TO BRIEF IN OPPOSITION

KENIA M. CINTRÓN PARRILLA
MIGUEL A. GARCÍA MÉNDEZ
(Pro se)
P. O. Box 388
Naguabo, Puerto Rico 00718
Telephone: 787-874-1359

QUESTIONS PRESENTED

1. Should the judgment and ruling of the court be inferred or it should be clearly stated beyond reasonable doubt?

2. Whether the time for an appeal starts to run when an order that finally rules on a motion requesting ruling for reconsideration is filed.

3. Should a motion requesting ruling for reconsideration under Federal Rules of Civil Procedure Rule 59(e) be defined or considered as a second motion for reconsideration?

4. Whether the Plan administrator under its authority may construe and interpret the term and conditions of the Plan and the Settlement Agreement at its convenience when the Agreement already construe all the terms condition and procedures that will govern the process?

5. Whether the terms, condition, and procedures under the Agreement preempt the terms, condition and procedures under the Plan?

6. Is there a conflict of interest when a person involved in the initial determination of the initial determination is also involved in the appeal determination?

7. Should the court interfere with the Plan Administrator's decision when it did not follow its own Plan's procedure, there is a conflict of interest and/or the decision to deny a disability claim lack of substantial evidence in the record to sustain such decision?

PARTIES

As per stated in the Second Amended Complaint filed on August 2, 2001, the parties are as follows (District Court Docket Document Number 42):

1. Kenia M. Cintrón Parrilla ("Mrs. Cintrón"), worked as an employee for Eli Lilly del Caribe, Inc., (before named Eli Lilly Industries, Inc.), Puerto Rico Branch, a subsidiary of Eli Lilly Industries, Inc. ("Lilly" or "Eli Lilly"), for approximately 20 years, as a chemist and senior quality assurance representative. As a Lilly employee Mrs. Cintrón is a participant in all of Lilly's E.R.I.S.A. plans and is entitled to the other employee benefits.

   Plaintiff-Petitioner

2. Miguel A. García Mendez ("Mr. García") is the husband of Kenia M. Cintrón Parrilla, and together they form a legal conjugal partnership.

   Plaintiff-Petitioner

3. Eli Lilly Industries, Inc. Health, and Welfare and Disability Plan, and/or Eli Lilly Puerto Rico Extended Disability Plan (the "Lilly Plan"), is an employee welfare benefit plan, and those terms are defined in Section 3 (1) and (3) of E.R.I.S.A., 29 U.S.C. sec. 1002 (1) and (3), and thus subject to the provisions of E.R.I.S.A., 29 U.S.C. §§ 1001 et seq. The Lilly Plan covers employees and former employees of Eli Lilly Industries, Inc. and/or Eli Lilly del Caribe, Inc., Puerto Rico Branch, and hence it covers the Plaintiff-Petitioner Kenia M. Cintrón Parrilla.

   Defendant-Respondent

4. Eli Lilly del Caribe, Inc. and/or Eli Lilly Industries, Inc., ("Lilly" or "Eli Lilly"), is a private corporation doing business in Puerto Rico, with its main business office

located in Carolina, Puerto Rico, and it is the administrator and/or fiduciary or trustee of the Lilly Plan for its Employees or former employees in Puerto Rico.

Defendant-Respondent

5. Company X is the health, welfare and disability plan of the Eli Lilly employees.

   Defendant-Respondent

6. Company Y is the administrator and/or fiduciary or trustee of the health, welfare and disability plan of the Eli Lilly employees, which is either natural or juridical person.

   Defendant-Respondent

7. Company A is the Eli Lilly Puerto Rico Employees Welfare Plan.

   Defendant-Respondent

8. Company B is the administrator and/or fiduciary or trustee of the Eli Lilly Puerto Rico Employee Welfare Plan.

   Defendant-Respondent

9. Company C is the Retirement Plan of Eli Lilly Industries Inc. and/or Eli Lilly del Caribe, Inc.

   Defendant-Respondent

10. Company D is the administrator and fiduciary or trustee of the Retirement Plan of Eli Lilly Industries, Inc., and/or Lilly del Caribe, Inc.

    Defendant-Respondent

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED.....	i
LIST OF PARTIES.....	ii
TABLE OF CONTENTS.....	iv
INDEX TO APPENDIXES	v
TABLE OF AUTHORITIES.....	vii
STATEMENT OF THE CASE.....	1
A. Reply To Respondents' Statement Of The Case.....	1
CERTIORARI SHOULD BE GRANTED.....	3
A. Reply To Standard For Granting Certiorari.....	3
B. The First Circuit Erred When Determine That Petitioners' Appeal Orders Was Untimely.....	4
C. The First Circuit Erred When Determined That The District Court Did Not Abuse Its Discretion in Denying Orders Timely Appealed.....	5
D. On the Merits, the First Circuit Erred When It Upheld Petitioners Extended Disability Claim Denial.....	6
CONCLUSION	10

INDEX TO APENDIXES

APPENDIX BA
Informative Motion and Plaintiff's First Set Of Interrogatories ..... App. 1

APPENDIX BB
Informative Motion and Co-Defendants' Lilly And The Plan's Answers And Objections To Plaintiff's First Set Of Interrogatories..... App. 7

APPENDIX BC
August 25, 2003 Charles A. Grandy Employee Benefits Committee And Fax Transaction Report..... App. 43

APPENDIX BD
August 25, 2003 Petitioners' Letter To Charles A. Grandy Employee Benefits Committee And Fax Transaction Report..... App. 46

APPENDIX BE
August 25, 2003 Appeal Committee's Denial Letter App. 52

APPENDIX BF
September 25, 2003 Letter requesting information for Denial According to Section 6.05 of the Plan App. 56

APPENDIX BG
Federal Rules of Appellate Procedure and First Circuit Local Rules Rule 4(a)4; Rule 10; Rule 11; Local Rule 26; Local Rule 27(a); Local Rule 27(c) App. 61

INDEX TO APENDIXES – Continued

APPENDIX BH

Federal Rules of Civil Procedure

VII. Judgment: Rule 54(b); Rule 58(a); Rule 58(b); Rule 58(d); Rule 59 (e); Rule 60 App. 68

APPENDIX BJ

PART 2560: Rules and Regulations for Administration And Enforcement

Sec. 2560.503-1: Claims procedure. App.73

TABLE OF AUTHORITIES CITED

FEDERAL CASES	Page
Acevedo-Villalobos v. Hernández 22 F.3d 384 (1st Cir. 1994).....	4
Donaho v. FMC Corporation 74F.3d 894 (8st Cir. 19996).....	10

FEDERAL STATUTES	PAGE
CFR Code of Federal Regulation Section 2560.503-1(m)(8).....	10
E.R.I.S.A.	4

FEDERAL RULES	Page
Federal Rules of Appellate Procedure Rule 26(a).....	5
Federal Rules of Appellate Procedure Rule 26(a)(1).....	5
Federal Rules of Appellate Procedure Rule 26(a)(2).....	5
Federal Rules of Appellate Procedure Rule 26(a)(3).....	5
Federal Rules of Appellate Procedure Local Rule 27(a).....	4
Federal Rules of Civil Procedure Rule 54(b).....	4

TABLE OF AUTHORITIES CITED- Continued

FEDERAL RULES	Page
Federal Rules of Civil Procedure Rule 58(d).....	5
Federal Rules of Civil Procedure Rule 59(e).....	4, 5, 6
Federal Rules of Civil Procedure Rule 60.....	5

OTHERS	Page
U.S. Constitution	4

STATEMENT OF THE CASE

For Statement of the Case refer the Petition for Writ of Certiorari ("Petition"), pages 4 to 21.

A. Reply To Respondents' Statement of the Case

Respondents' Brief in Opposition ("Opposition"), state incorrect and misleading information as explained herein. Respondents state that the Committee requested Mrs. Cintrón to undergo to independent medical evaluations ("IME's") to assist the Committee to complete its evaluation of her claim and, after her initial agreement to complete the evaluations, she failed to comply with the requests.

The letters that suggested the IME's were unclear and confused: 1) did not state which "Committee within Lilly" suggested the IME's, the Puerto Rico Committee, or the Eli Lilly and Company Employee Benefits Review Committee ("Review Committee") in Indianapolis; 2) it was required that the IME's needed to be rendered directly to Dr. Felix Matos[1] (Dr. Matos) of Lilly del Caribe[2]"; 3) the IME's were suggested, desirable, helpful not a requirement; and 4) the letters that referred to each other contained contradictory information. See Petition, App. 328, 332, 458, 459.

Also, Mrs. Cintrón's was limited to exercise one of two options: to submit to IME's, or to leave the matter to be decided based solely on the information submitted by her. Respondents never clarified Mrs. Cintrón's doubts such as: 1) why reports had to be rendered to Dr. Matos; 2) if the IME's were a requirement or not; 3) why the Review

---

[1] In-house physician for Lilly del Caribe in Puerto Rico

[2] Lilly del Caribe a Liliy Corporation doing business in Puerto Rico. See, this Reply, App 11, Answers And Specific Objections, item 1; and Petition, App. 104, Uncontested Facts, item A. 4.

Committee was not following the procedure under the Eli Lilly Extended Disability Plan ("Plan") the and Agreement.[3]

The better example of Respondents behavior was on November 4, 2002, when Mrs. Cintrón's attorney contacted Respondents' attorney "inquiring whether her submitting to an IME is mandatory" and the response was "I had addressed the issue in prior correspondence..." See Petition, App. 460.

Then, Mrs. Cintrón was force to choose between the two options and she opted to allow her claim to be decided with all the information she already submitted because, it was the only option that allowed her to protect her rights under the Agreement and the Plan. Mrs. Cintrón was always willing to cooperate in compliance with the Agreement and the Plan.

---

[3] The alleged procedure in which Dr. Matos might be involved is before a claim is submitted to the Review Committee, as follows: "In general terms the procedure that Lilly follows to evaluate disability claims is as follows. Employees who are absent from work due to illness/injury are evaluated by the Puerto Rico Employee Health Service's Department at least once a month. During said visits pertinent information and data is obtained. Laboratory exams and/or second opinions by other physicians may be requested, if necessary. Once the Puerto Rico Employee Health Service's Department physician evaluates all information and submits his/her recommendation of disability, the case is submitted to the Employee Benefits Committee in the United States for extended disability benefits consideration." See Petition, App. 97 and this Reply, App. 13-14, item 19. But, this is not the procedure under the Plan and the Agreement.

Pursuant to the Agreement, page 7, and footnote 4, and the Plan, Mrs. Cintrón would submit her disability claim and documentation directly to the "Review Committee" to the attention of Mr. John J. Purcell in Indianapolis, for its review and further determination, not to Dr. Matos.

One of most important reasons that led the parties to agree to submit the disability claim to Indianapolis and to assign Mr. John J. Purcell as a contact person was the improper handling of Mrs. Cintron disability case by Dr. Matos.

Respondents also state that Mrs. Cintrón appealed the denial and again failed to complete an IME, as requested. This information is false. Mrs. Cintrón clearly informed to the Eli Lilly and Company Benefit Plan Appeal Committee ("Appeal Committee") that she will undergo to medical examinations: 1) July 16: "Kenia will only undergo to medical examinations as per required and stated under section 6.02(b) of the Plan."; 2) August 22: "Kenia will still able to undergo to medical evaluation only as stated under section 6.02(b) of the Plan and signed by the parties in the Settlement Agreement."; 3) August 25: "...Kenia has never refused to undergo to medical evaluations as stated in section 6.02(b) of the Plan and signed by the parties in the Agreement. Kenia still willing to undergo to medical evaluations as stated on sections 6.02(b) and 6.05(b) of the Plan and signed by the parties in the Agreement." See Petition, App. 423, 428, 435.

Section 6.02(b) of the Plan states that the physician is "chosen by the Employees Benefits Committee"[4] (emphasis added). See Opposition, 52a. The Appeal Committee never arranged any medical evaluations for Mrs. Cintrón.

CERTIORARI SHOULD BE GRANTED

A. Reply To Standard For Granting Certiorari

Respondents state that "Petitioners have not presented any compelling reasons for this Honorable Court to exercise its discretionary jurisdiction over their attempted appeal of the dismissal of their claims."

---

[4] Petitioners proposed to have a physician chosen by both parties and/or the court at the time to sign the Agreement in the event of a discrepancy. Respondents refused alleging that this proposal was not stated in the Plan.

When the Honorable District Court denied Petitioners Request for Review and Petition for Oral Argument ("Request for Review") and finally ruled on the Reconsideration under Rule 59(e) on February 25, 2004, stated the reasons to deny the Request for Review referring to the whole record and to Respondents' Opposition to Request for Review. By this meaning, the District Court granted to Respondents to violate Petitioners civil rights under the U.S. Constitution, ERISA and Respondents breach of agreement, as explained herein. The Honorable Court of Appeals did the same, as well, when dismissed Petitioners' appeal and affirmed the Honorable District Court Orders under Fed. R. App. P. Local Rule 27(a), without even gave to Petitioners the opportunity to file a Brief on the Merits.

B. The First Circuit Erred When Determine That Petitioners' Appeal Orders Was Untimely

The August 14, 2002 Judgment and July 1, 2004 Order were disposed with the opportunity to be revisited. The final and conclusive order disposing them was the February 25, 2004 Order, according to Fed. R. Civil P. Rule 54(b).

Respondents also state: "After all "[a second] motion for reconsideration that is served more than ten days after the entry of the judgment has not effect upon the appeal time, which runs from the entry of the original order denying ... an alteration or amendment of the judgment" Acevedo-Villalobos, 22 F.3d at 389..." pursuant to Petitioners' Motion Requesting Our Motion for Reconsideration to be Denied or Granted ("Request of Ruling") for the December 19, 2003 Order, which did not have ruling. See Opposition, pages 6, 7.

In an intention to induce this Honorable Court to error, Respondents state the Request of Ruling filing date as January 8, when the correct filing date was January 7, 2004.

See District Docket #99 and Petition, App. 567. According to Fed. R. App. P. Rule 26(a) and Rule 4(a)4(a), it was filed within the ten (10) days period required.[5] Consequently, the First Circuit had jurisdiction and erroneously concluded that Petitioners were bared from seeking relief in connection with the November 24 and December 19, 2003 Orders.

C. The First Circuit Erred When Determined That The District Court Did Not Abuse Its Discretion in Denying Orders Timely Appealed

Respondents state: "The First Circuit has discretion to deny an appeal when it "clear appear[s] that no substantial question is presented", which would required it to consider the appeal." Petitioners presented substantial questions to the Honorable First Circuit. See Petition, App.495-505, 524-541.

Respondents also state that the District Court denied Petitioners Rule 59(e) motion to reconsider on December 19, 2003 stating that the case docket reflects that the court "terminated" the Motion for Reconsideration. The question here is, if a ruling should be inferred or should be stated beyond reasonable doubt and in the event of any doubt, if a ruling can be requested according to Fed. R Civil P. Rule 58(d) and Rule 60.

In this case the: 1) the Request for Review was denied without any explanation; 2) the Reconsideration under Rule

---

[5] According to Fed. R. App. P. Rule 26(a) the 10 day period to file the motion for Request of Ruling for the December 19, 2003 Order is computed as follows: December 19 is excluded, Fed. R. App. P. Rule 26(a)(1). December 20, 21, 25, 27, 28 and January 1, 3, 4, and 6 are Saturdays, Sundays and Legal Holidays, thus are excluded, Fed. R. App. P. Rule 26(a)(2). Therefore, the 10 days included are: December 22, 23, 24, 26, 29, 30, 31, and January 2, 5 and 7, Fed. R. App. P. Rule 26(a)(3). Thus, the January 7, 2003 motion was timely filed.

59(e) was filed without knowing the reasons for the denial; 3) the Reconsideration has two petitions to be addressed, to inform the reasons for the denial of the Request for Review and to reconsider the denial; 4) the December 19, 2003 Order addressed only one of the petitions. Thus, no judgment and/or ruling were made for the Reconsideration under Rule 59(e), 5) due to lack of ruling the Request of Ruling was timely filed on January 7, 2004. See Petition App. 8, 9, 464-481.

D. On the Merits, the First Circuit Erred When It Upheld Petitioners Extended Disability Claim Denial

Respondents allege that a list of physicians was provided to Mrs. Cintrón to provide flexibility to choose the physicians most convenient for her and the one she preferred. No relevant information about the physicians was given to Mrs. Cintrón to make an intelligent selection. The major situation here is that the Review and Appeal Committees did not follow the procedure under the Plan and the Agreement and intentionally changed and delayed the process to force Mrs. Cintrón to select physicians whom were unknown to her.

When Mrs. Cintrón became disabled she had one of her worst experiences when Dr. Matos referred her to a physiatrist, Dr. Marcos U. Ramos[6]; who reported false information and implied that Mrs. Cintrón was faking her disabling conditions. See this Reply, App.20-38. This awful experience led Petitioners to make the proposal stated in this Reply, footnote 4, page 3.

This insistence to force Mrs. Cintrón to select physicians had only one intention, to bind her to any decision and/or

---

[6] Petitioners filed a law suit against Dr. Marcos U. Ramos in the Puerto Rico Court; he was never found nor his alleged office could never be identified as such when the summons was tried to be served

opinion made by such physicians. Mrs. Cintrón decided to follow the Plan and the Agreement as written in order to protect her rights.

Respondents state that Mrs. Cintrón was informed of the Review Committee's decision on December 2, 2002[7], this is false. The letter was received by Mrs. Cintrón on December 10, 2002 and postmarked on December 6, 2002[8], after the deadline to render a decision had expired, pursuant to Section 6.05 of the Plan and the Agreement. See Opposition, page 54a, and Petition, Appendix AY, page 9, (Filed Under Seal).

Respondents also state that Mrs. Cintrón did not provide new information to the Appeal Committee. That is also false. On May 29, 2003, Mrs. Cintrón submitted new evidence of physicians whom had evaluated her to the Appeal Committee that was not previously submitted to the Review Committee such as: Neurological Reports by Dr. Tomás Hernández; Thoracic Surgery Evaluation by Dr. Elizardo Matos; Hand Surgery Evaluation by Dr. Jan Pierre Zegarra; Comprehensive Spine Consultation by Dr. Paul Zak; Social Security Administration Notice, dated Apr. 25, 2003. See Petition, App. 363-414.

Respondents state that on July 16, Mrs. Cintrón did not agree to attend IME's, this is also false. As herein explained, the Appeal Committee did not arrange any the medical evaluation for Mrs. Cintrón and intentionally delayed and changed the process in an effort to force her to amend the Agreement with the only intention to cover their failure to comply with the Plan and the Agreement.

---

[7] Respondents arbitrarily established the December 2, 2002 date as the deadline to inform Mrs. Cintrón of the Review Committee final decision but the correct deadline date was November 29, 2002.

[8] See Petition, Appendix AZ, page 40, (Filed Under Seal.)

Moreover, by a letter August 25, 2003, Mrs. Cintrón was allowed until noon (12:00 p.m.) of August 26 to sign the amendment to the Agreement. Mrs. Cintrón declined the proposal on letter dated August 25, 2004, but this letter was not faxed until August 26, 2003. However, by letter dated August 27, 2003, on the first paragraph, the Appeal Committee admitted that they met on August 25, 2003 and denied Mrs., Cintrón disability claim that same day. See Petition, App. 429-440 and this Reply, App. 43-55. The alleged opportunity supposedly given to Mrs. Cintrón to amend the Agreement for medical evaluations was a sham.

The Review and Appeal Committees denied Mrs. Cintrón disability claim because she exercise her right to "choose or not to choose" physicians and her right "to agree or not to agree" to accept changes to the Plan and Agreement signed by the parties.

Even though, Mrs. Cintrón submitted more that enough evidence that supports her disability, the Review and Appeal Committees insisted that Mrs. Cintrón failed to submit data that supports her disability claim. Arbitrarily, capricious and in abuse of discretion, the Review and Appeal Committees just selected the data that states "mild degenerative disc disease", subjectively concluded that "the data was poorly correlated to the diagnostic studies" and disregarded all the data that supports all Mrs. Cintrón disabling conditions since 1997, in order to deny her disability claim. The question is: how can physicians determine if Mrs. Cintrón was disabled since 1998 if they had never evaluated her during that period of time? However, the medical records that Mrs. Cintrón submitted support her disability since 1997.[9]

---

[9] Mrs. Cintron disabling conditions which among others are: bilateral carpal tunnel and thoracic outlet syndromes, cervical myositis, cervical

The Plan in Section 6.05(b) states:

"The review of the adverse benefit determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the Employee Benefits Committee ... and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker subordinate"

See Opposition, page 57a and 58a

The Appeal Committee not only afforded full deference to the initial denial, made the same determination and for the same reasons. Also, used almost exactly the same wording and distorted process to evaluate and deny Mrs. Cintrón's claim. Moreover, Mr. John J. Purcell[10] (contact person) who signed both denial letters was also a member of the Review and Appeal Committees. See, Petition, App. 351-355, 437-440. This is evidence that decision-makers involved in both Committees are the same in a clear conflict of interest.

Furthermore, Plan at Section 6.05 states: "The health care professional who is consulted on the appeal will not be the

---

and lumbar radiculopathy, fibromyalgia, chronic anxiety with depression, swelling and tenderness of trapezius and shoulders, light pushing of artery, chronic cervical, thoracic and lumbar myofacial pain, fiber tenosynovitis, mild degenerative disc disease, cervical and lumbar spine, bilateral C5-6 root lesion, neuropathy. See Petition, App. 185-325, 334-341, 343-348, 366-414.

[10] Mr. John Purcell seems to have various positions in Review and Appeal Committees such as: Manager Employee Benefits, Benefit Plan Review Committee Secretary, Employee Benefit Committee Secretary, Employee Benefits Committee See, Petition, App. 350, 355, 361, 418, 440, 442.

individual who was consulted during the initial determination or his subordinate...". However, the list of the physicians provided to Mrs. Cintrón by the Review and Appeal Committees was the same. See Opposition, page 58a and Petition, App. 328, 329, 415, 416.

The Plan in Section 6.05 also states: "Claimants will have access to all relevant documents (within the meaning of Lab. Reg. §2560.503-1(m)(8)) and may request the identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination..." See, Opposition page 57a. Accordingly, Mrs. Cintrón sent a letter dated September 25, 2003 requesting said information, which has not been answered up today. See this Reply, App. 56-60

Respondents states: "Thus, absent bad faith or conflict of interest, a court may only overturn a plan administrator's decision if it is "...without reason, unsupported by substantial evidence or erroneously as a matter of law." Donaho, 74 F.3d at 900." Precisely, this is the situation in this case.

CONCLUSION

Both the Review and Appeal Committees acted in bad faith, arbitrary, capricious, in an abuse of discretion, in a clear conflict of interest and in a breach of agreement. The whole disability claim evaluation and determination process was a sham. Therefore, the petition for a writ of certiorari should be granted.

Respectfully submitted,

Kenia M. Cintrón Parrilla

Miguel A. García Méndez

APPENDIX BA

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

KENIA M. CINTRON PARRILLA,	*	
Plaintiff	*	
v.	*	Civil No.
ELI LILLY DEL CARIBE, INC.,	*	99-1229 (JAF)
et al.,	*	
Defendants	*	

INFORMATIVE MOTION

TO THE HONORABLE COURT:

Comes now plaintiff, Kenia M. Cintron Parrilla, by her counsel, and respectfully informs this Honorable Court that on this same date a First Set of Interrogatories was submitted to the defendants, through their legal representation, by way of certified mail, return receipt requested.

WHEREFORE, plaintiff respectfully informs this Honorable Court.

In San Juan, Puerto Rico, on this 1st day of February 2001.

I hereby certify that on this same date a true copy of this motion was mailed to: Carl Schuster, Esq. and Lizette Velez Rive, Esq., P.O. Box 363128, San Juan, P.R. 00936-3128.

HERNANDEZ SANCHEZ LAW FIRM
First Bank Building, Suite 806
1519 Ponce de Leon Ave.
San Juan, PR 00909-1791
Tel. 722-5814; Fax: 725-1112
By: /s/ Guillermo Macari
Guillermo Macari USDC-PR 206308

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

KENIA M. CINTRÓN PARRILLA, Plaintiff v. ELI LILLY DEL CARIBE. INC., et al., Defendants	Civil No. 99-1229 (JAF)

FIRST SET OF INTERROGATORIES

TO: ALL THE DEFENDANTS
Through their legal representation

FROM: PLAINTIFF KENIA M. CINTRON PARRILLA
Through her legal representation

COMES NOW plaintiff Kenia M. Cintron Parrilla, through the undersigned attorneys, and pursuant to Rule 33 of the Federal Rules of Civil Procedure notifies and submits to defendants the following interrogatories to be answered separately, in writing and under oath, within the legal term of thirty (30) days, starting from the date of this requirement and notification.

To the person answering these interrogatories:

1. State your full name, occupation, residential and work address and Social Security number.

2. State your detailed theory of this case.

3. State the exact date in which Mrs. Kenia M. Cintron began working for Eli Lilly del Caribe, Inc.

4. State the exact date in which Mrs. Cintron was assigned the project which required her to use a computer for approximately six to seven hours per workday.

5. State Mrs. Cintron's monthly salary history as an Eli Lilly del Caribe employee.

6. State the exact date in which Dr. Felix Matos examined Mrs. Cintron.

7. State the basis of Dr. Matos' decision to refer Mrs. Cintron to the State Insurance Fund.

8. State the result of the first diagnostic made by the State Insurance Fund on Mrs. Cintron's medical condition.

9. State specifically in what did Eli Lilly and/or its representatives or employees based their doubts that Mrs. Cintron's condition was work related.

10. State the exact agreement reached between Mrs. Cintron and Dr. Felix Matos, Ricardo Flores and Raquel Llavina on August 15, 1997.

11. Please explain the relationship between Eli Lilly and Dr. Marcos U. Ramos, physiatrist.

12. State Dr. Marcos U. Ramos' diagnostic on Mrs. Cintron

13. State and explain specifically the basis of the decision made by Eli Lilly and/or its representatives or employees that they could not respect the agreement reached on August 15, 1997.

14. List the full names, residential and work addresses and relationship with Eli Lilly and/or Health Welfare and Disability Plan (the Plan) of each of the members of the committee that would reassess Mrs. Cintron's case.

15. State wether this internal committee was the Employee Benefits Committee or not. If the answer is no,

please state the full names, residential and work addressess and relationship with Eli Lilly and/or Health Welfare and Disability Plan (the Plan) of each of the members of the Employee Benefits Committee.

16. State wether Mrs. Cintron was informed that the internal committee was the Employee Benefits Committee or not. If the answer is yes, state the full names, residential and work addressess and relationship with Eli Lilly and/or Health Welfare and Disability Plan (the Plan) of each of the persons that informed Mrs. Cintron and the exact date she was informed.

17. State the basis of the decision made by Eli Lilly and/or Health Welfare and Disability Plan (the Plan) and/or its representatives or employees that Mrs. Cintron was not entitled to receive any supplementary payments due to an occupational illness.

18. State the basis of the decision made by Eli Lilly and/or Health Welfare and Disability Plan (the Plan) and lor its representatives or employees that Mrs. Cintron was not entitled to receive extended disability benefits.

19. State the exact procedures that Eli Lilly and/or Health Welfare and Disability Plan (the Plan) and/or its representatives or employees use to evaluate disability claims.

20. State the exact date that Mrs. Cintron's employment was terminated by Eli Lilly del Caribe.

21. State the exact reasons for Mrs. Cintron's employment termination.

22. List all the persons you know that have any personal knowledge of the facts that led to this lawsuit, stating for each one his or her full name, age, occupation, residential and work address and relationship with defendants.

23. List all the documental evidence you will present at trial, stating for each one:

a. Date document was prepared.

b. Full name, residential and work address and relationship with Eli Lilly and/or Health Welfare and Disability Plan of the person preparing the document.

24. List all the witnesses you are planning to call at trial stating for each one his or her full name, age, occupation, residential and work address and relationship with defendants and a brief summary of their intended testimony.

25. List all the expert witnesses you are planning to call at trial stating for each one his or her full name, age, occupation, residential and work address, qualifications as expert witnesses and a brief description of the purpose of their expert testimony.

In San Juan, Puerto Rico, on February 1, 2001.

HERNANDEZ SANCHEZ LAW FIRM
First Bank Bldg. Suite 806
1519 Ponce de Leon Ave.
Santurce, Puerto Rico 00909-1791
TEL. 722-5814/5813
FAX. 725-1112

BY: /s/ Guillermo Macari
Guillermo Macari
USDC-PR 206308

Certified Mail # Z 414 607 713. Return receipt requested.

APPENDIX BB

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

KENIA M. CINTRON PARRILLA, ET AL. Plaintiff Vs. ELI LILLY INDUSTRIES, INC.; HEALTH WELFARE AND DISABILITY PLAN; LILLY DEL CARIBE, INC.; COMPANY X; COMPANY Y Defendants	Civil No. 99-1229 (JAF)

INFORMATIVE MOTION

TO THE HONORABLE COURT:

COME NOW co-defendants, Lilly Del Caribe, Inc., Eli Lilly Industries, Inc. (hereinafter referred to as "Lilly") and Eli Lilly Industries, Inc., Health, Welfare and Disability Plan (hereinafter referred to as the "Plan"), through their undersigned attorneys, and respectfully inform this Honorable Court that on this same date they have served by certified mail return receipt requested co-plaintiff, Kenia Cintron Parilla, through her attorney of record, Jesus Hernandez Sanchez, Esq., Co-Defendant's Lilly and the Plan's Answers and Objections to Plaintiff's First Set of Interrogatories and Notice of Taking of Deposition for co-plaintiff Miguel A. Garcia Méndez.

WHEREFORE, defendant respectfully requests that this Honorable Court take notice of the aforementioned.

Respectfully submitted.

In San Juan, Puerto Rico, this 19th day of April, 2001.

It is certified that this Informative Motion, was sent by regular mail to plaintiffs' counsel of record, Jesus Hernandez Sanchez Esq., Hernandez Sanchez Law Firm, First Bank Building, Suite 806, 1519 Ponce de Leon Ave., San Juan, Puerto Rico 00909-1791.

SCHUSTER USERAAGUILO & SANTIAGO LLP
PO Box 363128
San Juan, Puerto Rico 00936-3128
Telephone (787)765-4646/ Fax 765-4611

/s/ Lizette Velez Rive
LIZETTE VELEZ-RIVE
USDC-PR No. 209002

H:\VELEZL\LILLY.CAR\CINTRON\FED2\informative motion.02.wpd

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

KENIA M. CINTRON PARRILLA, ET AL. Plaintiff Vs. ELI LILLY INDUSTRIES, INC.; HEALTH WELFARE AND DISABILITY PLAN; LILLY DEL CARIBE, INC.; COMPANY X; COMPANY Y Defendants	Civil No. 99-1229 (JAF)

CO-DEFENDANTS' LILLY AND THE PLAN'S ANSWERS AND OBJECTIONS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

TO: CO-PLAINTIFF KENIA M. CINTRON PARRILLA
through her attorney,
Jesus Hernandez Sanchez, Esq.
Hernandez Sanchez Law Firm
First Bank Building, Suite 806
1519 Ponce de Leon Ave.
San Juan, Puerto Rico 00909-1791

PRELIMINARY STATEMENT

Pursuant to the Federal Rules of Civil Procedure, co-defendants Lilly Del Caribe, Inc., Eli Lilly Industries, Inc., (hereinafter referred to as "Lilly") and Eli Lilly Industries, Inc., Health, Welfare and Disability Plan (hereinafter referred

to as the "Plan") - submit their responses to plaintiff's First Set of Interrogatories.

The answers provided are based upon information as is reasonably available. As required by the Federal Rules of Civil Procedure, the answers to these interrogatories provide full, fair and specific information through reasonable efforts to obtain such information. Nevertheless, Lilly and the Plan will supplement these responses as additional information or documentation comes to its attention.

GENERAL OBJECTIONS

1 Lilly and the Plan object to any effort to require defendants to search for documents or information in the possession, custody or control of unnamed entities and/or plaintiff as being unduly burdensome, vexatious and harassing.

2. Lilly and the Plan object to each of the interrogatories to the extent they seek information or documents protected from disclosure under the attorney-client, or other privilege, or the work-product doctrine.

3. Lilly and the Plan object to each of the interrogatories to the extent they seek information or documents which pertain to or originated in the period subsequent to March 5, 1999, the date on which the plaintiff filed its complaint.

4. Lilly and the Plan object to each of the interrogatories to the extent they seek information or documents relating to subjects outside of the scope of the complaint and the allegations and causes of action raised therein.

5. Lilly and the Plan make all of the objections and responses contained herein, including its General Objections and specific responses and objections, while reserving the right to make additional objections as may be deemed appropriate upon further review of information or documents.

DEFINITIONS

The following definitions are incorporated by reference in all of Lilly and the Plan's specific responses and objections to plaintiff's First Set of Interrogatories:

1. "*Irrelevant*" means not relevant to the issues involved in the pending action and not reasonably calculated to lead to the discovery of evidence admissible as to those issues.

2. "*Overbroad*" means irrelevant, burdensome, and unnecessary to the extent the set of interrogatories seek (1) information about the period after March 5, 1999; (2) information about individuals or entities not parties to this actions; and/or (3) any other information pertaining to persons, activities and events that are not reasonably in issue in this action.

3. "*Vague*" means ambiguous or not specified with reasonable particularity.

4. "*Unduly burdensome*" means that it is impossible to provide a response that is complete and sufficient without making an unreasonably complex or onerous investigation or incurring unreasonable expense.

5. "*Defendants*" means exclusively Lilly Del Caribe, Inc., Eli Lilly Industries, Inc., and Eli Lilly Industries, Inc., Health, Welfare and Disability Plan.

ANSWERS AND SPECIFIC OBJECTIONS

1. Ileana Rivera, Human Resources Director, Lilly del Caribe, Inc., PO Box 1198 Carolina, Puerto Rico 00986. The rest of the information requested in this interrogatory is objected on the basis that it is irrelevant to the allegations presented in this case.
2. Interrogatory number two (2) is objected on the basis that it requires a conclusion of law.

3. September 26, 1977.
4. To the best of my knowledge, it is Lilly and the Plan's position that during Cintron's years of employment at Lilly, plaintiff was not assigned to a project which required her to use a computer for approximately six to seven consecutive hours per workday.
5. The information requested is attached as Exhibit 1.
6. Interrogatory number six (6) is objected on the basis that it is overbroad and vague.
7. Dr. Felix Matos referred Cintron to the State Insurance Fund in view of the medical certificate from Dr. Tomas Hernandez dated June 17, 1997 referring her to the State Insurance Fund brought by Cintron.
8. Interrogatory number eight (8) is objected on the basis that it is overbroad and vague. Notwithstanding the objection, the information requested is in the control of the State Insurance Fund.
9. Lilly based its doubts that Cintron's condition was work related on the following, among others: 1) on or around June 1997, the severity of her condition and her medical history in conjunction with her work history did not seem to originate from the workplace; 2) on or around March 1997 Cintron's job required her to work a couple of hours a day on the computer; 3) Cintron's job required her to spend most of her time reading books in order to compare gaps in the pharmacopeia; 4) Cintron's symptoms were not typical of computer related problems for the estimated time spent at the computer; 5) in June 1997, Lydianne Secola performed an ergonomic study of Cintron's work area which revealed that Cintron had bad posture at her workstation; 6) Cintron's condition did not improve with rest and physical therapies while away from work; 7)

Cintron's condition seemed to be systemic in nature rather than work related; 8) Cintron developed an alleged emotional condition while away from work.

10. Interrogatory number ten (10) is objected on the basis that it is overbroad and vague. Notwithstanding the objection, no exact agreement was reached during the August 15, 1997 meeting held between plaintiff, Dr. Felix Matos, Raquel Llivina and Ricardo Flores.
11. None. As with any other physician, the Company refers cases to Dr. Marcos U. Ramos.
12. Please refer to Dr. Marcos Ramos evaluation report regarding plaintiff, attached as Exhibit 2.
13. N/A. Please refer to answer to interrogatory number ten (10).
14. Interrogatory number fourteen (14) is objected on the basis that it is overbroad and vague.
15. Interrogatory number fifteen (15) is objected on the basis that it is overbroad and vague.
16. Interrogatory number sixteen (16) is objected on the basis that it is overbroad and vague.
17. Please refer to answer to interrogatory number nine (9). Inasmuch as the Company believed that plaintiff's illness was not work related, plaintiff's supplementary payments were denied in compliance with Company policies and procedures.
18. Please refer to Exhibit 3.
19. In general terms the procedure that Lilly follows to evaluate disability claims is as follows. Employees who are absent from work due to illness/injury are evaluated by the Puerto Rico Employee Health Service's Department at least once a month. During said visits

pertinent information and data is obtained. Laboratory exams and/or second opinions by other physicians may be requested, if necessary. Once the Puerto Rico Employee Health Service's Department physician evaluates all information and submits his/her recommendation of disability, the case is submitted to the Employee Benefits Committee in the United States for extended disability benefits consideration.

20. December 23, 1998.

21. Please refer to Exhibit 3.

22. At this time, Lilly and the Plan have identified the following persons who may have knowledge of some of the facts alleged in the Complaint: Ricardo Flores, former Lilly's Human Resources Director; Ileana Rivera, Lilly's Human Resources Director; Dr. Felix Matos, Lilly's In-House Physician; Raquel Llivina, Human Resources Manager at the time of the facts alleged in the Complaint; Lydianne Sécola, Health & Safety Leader; Luz. E. Soto, Compliance Officer; Evelyn Rodriguez, Director of Quality Assurance. There may be, however, other persons which may have knowledge of the facts alleged in the Complaint. The rest of the information requested in this interrogatory is objected on the basis that it is irrelevant to the allegations presented in this case.

23. Lilly and the Plan have not made a final decision as to the evidence they will present at trial. At this time Lilly and the Plan anticipate that they will be using the following documents as evidence in the case: 1) plaintiff's medical record with the Company; 2) Lilly's Employee Manual; 3) plaintiff's personnel file with Lilly and; 4) Eli Lilly Puerto Rico Extended Disability Plan. Co-defendants Lilly and the Plan, however, reserve the right to

supplement their documentary evidence list pursuant to the pending discovery.

24. Lilly and the Plan have not made a final decision as to the witnesses they will present at trial. At this time Lilly and the Plan anticipate that they will be using the following witness in the case: 1) Ricardo Flores; 2) Ileana Rivera; 3) Raquel Llivina and; 4) Dr. Felix Matos. Co-defendants Lilly and the Plan, however, reserve the right to supplement their witness list pursuant to the pending discovery. The rest of the information requested in this interrogatory is objected on the basis that it is irrelevant to the allegations presented in this case.

25. Lilly and the Plan are not anticipating to call expert witnesses at this time. Co-defendants Lilly and the Plan, however, reserve the right to announce expert witnesses pursuant to the pending discovery.

I, Ileana Rivera, in my capacity as Human Resources Director of Lilly Del Caribe Inc. ("Lilly") declare under penalty of perjury under the laws of the United States of America that all of the foregoing is true and correct to the best of my personal knowledge and on the basis of the information made available to me.

WHEREFORE, I subscribe the present statement in San Juan, Puerto Rico, on this 19th day of April, 2001.

/s/ Ileana Rivera
Ileana Rivera

In San Juan, Puerto Rico, this 18 day of April, 2001.

WE CERTIFY: On this same date we have notified a true and exact copy of the foregoing writ, by certified mail return receipt requested, to plaintiff's attorney of record, Jesús

Hernández Sánchez Esq., Hernández Sánchez Law Firm, First Bank Building, Suite 806, 1519 Ponce de Leon Ave., San Juan, Puerto Rico 00909-1791.

SCHUSTER USERA AGUILO & SANTIAGO
P. O. Box 363128,
San Juan, Puerto Rico 00936-3128
Tel. 765-4646/Fax '765-4611

/s/ Lizette Velez-Rive
LIZETTE VELEZ-RIVE
USDC-PR No. 209002

H:\VELEZL\LLLLY.CAR\CINTRON\FED2\answer interrogatories.wpd

Exhibit I[1]

PROG: PERSCD-440 Eli Lilly Industries, Inc. Date: 02/19/01
Carolina, P. R. Page: 01
Salary Card

Employee Name	Emp. Number	Date of Transfer
Kenia M. Cintron	584-66-4691	
Date of Entry	Service Credit Years	
09/26/77	0	

Effective Date	Reason	Dept	Job Title	Salary Class	Years
03/01/79	NC	63P	Chemist	F	1.06
06/01/79	CF	63P	Chemist	F	1.09
09/01/79	M	63P	Chemist	F	2.00
03/01/80	MP	64P	Laboratory Supervisor	G	2.06
09/01/80	M	64P	Laboratory Supervisor	G	3.00
03/01/81	S	64P	Laboratory Supervisor	G	3.06
03/03/81	CF	64P	Laboratory Supervisor	G	3.06
09/01/81	LP	64P	Laboratory Supervisor	H	4.00
01/01/82	DC	38J	Laboratory Supervisor	H	4.04
03/01/82	TC	38J	Supervisor Laboratory	H	4.06
06/01/82	DC	43J	Sr. Q.C. Representative	H	4.09
03/26/83	NC	43J	Sr. Q.C. Representative	H	5.06
09/01/83	M	43J	Sr. Q.C. Representative	H	6.00
03/26/84	NC	43J	Sr. Q.C. Representative	H	6.06
09/01/84	M	43J	Sr. Q.C. Representative	H	7.00

[1] This report identified as Exhibit I was provided to plaintiff's attorneys and apparently appears to be incomplete and altered manner.

Effective Date	Reason	Dept	Job Title	Salary Class	Years
03/26/85	NC	43J	Sr. Q.C. Representative	H	7.06
09/01/85	M	43J	Sr. Q.C. Representative	H	8.00
09/01/86	LP	42J	Sr. Q.C. Representative	I	9.00
03/26/87	NC	42J	Sr. Q.C. Representative	I	9.06
09/01/87	M	42J	Sr. Q.C. Representative	I	10.00
03/26/88	NC	42J	Sr. Q.C. Representative	I	10.06
09/01/88	LP	42J	Sr. Q.C. Representative	J	11.00
03/26/89	NC	42J	Sr. Q.C. Representative	J	11.06
07/01/89	BP	49J	Supervisor	K	11.10
09/01/89	M	49J	Supervisor	K	12.00
03/26/90	NC	49J	Supervisor	K	12.06
09/01/90	M	49J	Supervisor	K	13.00
01/02/91	FI	49J	Supervisor	K	13.04

Effective Date	Salary Range Min.	Max	Present	Recommended	Appoved	Perf
03/01/79	920.00	1250.00	895.00	0.00	0.00	0
06/01/79	995.00	1325.00	895.00	966.00	966.00	0
09/01/79	1040.00	1380.00	966.00	1070.00	1070.00	0
03/01/80	1115.00	1610.00	1070.00	1170.00	1170.00	0
09/01/80	1145.00	1650.00	1170.00	1290.00	1290.00	0
03/01/81	1145.00	1650.00	1290.00	**1400.00**	**1415.00**	0
03/03/81	1275.00	1900.00	1415.00	1543.00	1543.00	0
09/01/81	1380.00	2060.00	1543.00	1695.00	1695.00	0
01/01/82	1380.00	2060.00	1695.00	0.00	0.00	0
03/01/82	1380.00	2165.00	1695.00	0.00	0.00	0
06/01/82	1380.00	2165.00	1695.00	0.00	0.00	0

Effective Date	Salary Min	Range Max	Present	Recommended	Appoved	Perf
03/26/83	1400.00	2195.00	1845.00	0.00	0.00	0
09/01/83	1415.00	2225.00	1845.00	1985.00	1985.00	4
03/26/84	1515.00	2385.00	1985.00	0.00	0.00	0
09/01/84	1530.00	2405.00	1985.00	2115.00	2115.00	3
03/26/85	1530.00	2405.00	2115.00	0.00	0.00	0
09/01/85	1550.00	2430.00	2115.00	2265.00	2265.00	4
09/01/86	1885.00	2915.00	2355.00	2535.00	2535.00	4
03/26/87	1990.00	3075.00	2535.00	0.00	0.00	0
09/01/87	2005.00	3095.00	2535.00	2750.00	2750.00	4
03/26/88	2660.00	3255.00	2750.00	0.00	0.00	0
09/01/88	2805.00	3465.00	2750.00	2985.00	2985.00	4
03/26/89	2975.00	3675.00	2985.00	0.00	0.00	0
07/01/89	3620.00	4480.00	2985.00	**0.00**	**3100.00**	0
09/01/89	3710.00	4535.00	3100.00	3345.00	3345.00	4
03/26/90	3914.00	4784.00	3345.00	0.00	0.00	0
09/01/90	3914.00	4784.00	3345.00	3590.00	3590.00	4
01/02/91	4377.00	5412.00	3590.00	3877.00	3877.00	0

Exhibit II

ASSOCIATE PROFESSOR
DEPARTMENT OF REHABILITATION MEDICINE
BOSTON UNIVERSITY SCHOOL OF MEDICINE
MARCOS U. RAMOS, M.D., F.A.A.P.M. & F
FORMER ASSISTANT CHIEF
DEPARTMENT OF REHABILITATION MEDICINE
UNIVERSITY HOSPITAL
1977-1969

August 7, 1997

Felix V. Matos, M.D.
Medical Director
Eli Lilly Industries, Inc.
Call Box 1198
Pueblo Station
Carolina, Puerto Rico 00985-1198

RE: Kenia M. Cintron-Parrilla
DOB: 02-17-56
SSN: 584-66-4691
DOI: May 1997
DATE OF EXAM: August 6, 1999

Dear Dr. Matos:

Thank you kindly for referring your employee, Mrs. Cintron, for evaluation. She was evaluated on the above-noted date **in my Puerto Rico office**.

This 41-year old female used to work as a regulatory compliance officer for Eli Lilly Industries until June 18,

1997, when, she stated, she was unable to continue working. She described her last occupational duties as performing mostly office work, working on the computer, typing reports, etc... Recently, she stated, she was involved in a project which required transferring data from books and from other reports. Professionally, she holds a bachelor's degree in chemistry.

On commenting further about her occupation, she stated, she is not really a typist, rather, she stated she needs to look at the keyboard in order to type. She described her work station as a sit-down station with a computer video display terminal in front of her, somewhat higher than usual. She has a low keyboard and, since there is no space for the mouse to be kept close to the keyboard, the mouse is located on the left-hand side of the video display terminal (her right side). She further described how she places the material to be copied into the computer on her right- hand side, requiring her to perform right-rotation/right-lateral flexion of the neck in order to read the material, then coming back to the anatomical position looking downward at the keyboard and then looking upward at the video display terminal.

The history of the onset of symptoms in question dates back to some time in **May 1997.** She stated that while shopping at a store with her daughter she extended her right arm to reach for something when she developed severe and sudden pain in the right arm. The pain, she stated, was accompanied by a sensation of loss of strength in the entire right arm. She denied any similar previous episodes, either at work or at home. She denied any direct trauma, any sudden event, or any other causative factor to explain those symptoms.

She was seen by a physiatrist who examined her and told her she had "spasms in the neck". She was then referred to a neurologist who performed an EMG. According to Mrs. Cintron, that test was abnormal. She continued working, however, the symptoms continued with pain, now in both arms, both hands, with stabbing pains in both elbows and pain up into the neck and, lately, into the upper and lower back regions. In addition, she mentioned she has noticed numbness in the lateral aspect of the thighs, in the calves, and in the toes. As mentioned, she has been out of work since June 18, 1997.

Upon describing her present status, she mentioned she continues with severe pain in both shoulders, mostly on the right side, along with pain in both elbows, headaches, pain in the neck, pain in the upper and lower back, pain in both thighs, tingling down into the toes. At present she is on Norflex, Relafen, Zantac, and vitamin C supplement.

The past history was extremely significant and includes two previous occupational incidents and other trauma as follows:

1984, she stated, she developed some pain in the neck and in the back. At that time she was seen by a rheumatologist. Apparently some blood samples were obtained, however, she does not remember the results of those studies. She was also seen by a physiatrist, Dr. Lao. An EMG of the lower extremities was performed and at that time she was told she had "spasms". No other diagnosis was apparently established.

1991 - 1992 At that time, she stated, and while working and being exposed to the chemical Lorabid she developed an episode of bronchial asthma. She was out of work for one and one-half months. She was treated and, according to her, she has recovered completely with no residuals.

In **August/September 1995,** she stated, she experienced an episode of unconsciousness. She mentioned that on a Saturday while at home she was found on the floor by one of her neighbors, apparently unconscious. She does not remember any trauma, no preceeding aura, nor any abnormal movements, any seizures, or the like. According to her, she may have been on the floor for approximately one hour; however, there were no abrasions, lacerations, or hematomatas. She was taken to a local hospital and, according to her, she "could not remember things and had amnesia." An MRI was performed and, she stated, she was told she may have, perhaps, a "frontal lobe inflammation". However, according to her, no specific diagnosis was ever established. She has sustained no other similar episodes.

November/December 1996 At that time, she stated, while walking on the premises of the company she tripped on the edge of a rug and fell. There were, however, no injuries sustained and no time lost from work.

The rest of the past medical history includes a cholecystectomy, an appendectomy, a tubal ligation, and left oophorectomy. In 1985 she underwent a reduction mammoplasty and an abdominoplasty.

Major Illnesses: February 1996 At that time she suffered a major gastrointestinal infection with acute diarrhea and dehydration. She was admitted to a hospital where she remained for four days. She was treated with antibiotics. She was told she either had a virus or a salmonella or Shigella infection. She did well with no reoccurrences.

She is said to be allergic to Percocet and Lorabid.

A female clinical assistant remained present with Mrs. Cintron and this examiner throughout the entire physical examination process.

On examination, Mrs. Cintron could be described as a well-developed, short-statured, moderately obese adult female in no acute distress who appeared very pleasant, cooperative, and quite jovial. It is significant to observe that all the rather serious pieces of medical information mentioned above were offered in a rather jovial and "matter-of-fact" manner by Mrs. Cintron. Her gait was normal and she was using no assistive devices.

The blood pressure in the right arm was 140/92, and 132/88 in the left arm. The pulse was 78 beats per minute. Her height was 62 inches, and her weight was 164 pounds.

Examination of the scalp, eyes, ears, nose, and throat were unremarkable. Initially, on attempting direct examination of the mobility of the neck she moved the neck so minimally that it became quite obvious that Mrs. Cintron was attempting to affect the results of the examination. In view of this, the examination of the scalp, eyes, ears, nose, and throat were repeated. This time and on indirect examination the cervical excursion she voluntarily produced without outside help was quantitatively measured using a dual inclinometer system according to the standard protocol established by the American Medical Association. These values, as mentioned, are the ones she voluntarily produced during indirect examination and may not necessarilly represent the maximal available cervical motion. Those values were recorded in degrees of motion as follows:

Right Rotation	0 to 70
Left Rotation	0 to 65
Flexion	0 to 60
Extension	0 to 65
Right Lateral Flexion	0 to 45

Left Lateral Flexion 0 to 45

Both carotids were clear. No bruit was noted on auscultation over the supraclavicular regions both with the arms in the anatomical position and in a position of maximal elevation. Auscultation and percussion of both lung fields elicited clear breath sounds bilaterally. Auscultation of the heart limited to the aortic and pulmonic focci only elicited a regular rhythm of 84 beats per minute. No murmurs or gallops were audible.

Clinical examination of the abdomen was unremarkable. There was a 4" surgical scar over the right upper quadrant, and a 1 1/2" surgical scar over the right lower quadrant, as well as a 6" surgical scar of the suprapubic region, and an 8" surgical scar under each breast at the thoraco-abdominal junction. All those scars were well-healed, non-tender, and non-adherent. No incisional hernias were present. The breasts, genital, and rectal areas were not exposed. Those areas were not examined.

The neurological examination of this right-hand dominant, well-oriented adult female was non-focal. The cranial nerves function was grossly normal and equal bilaterally with no asymmetries. The peripheral neurological examination was also performed and those findings, too, were negative. The deep tendon reflexes over both upper and both lower extremities were normoreactive and grossly equal. No long tract signs were noted. No pathological reflexes were present.

The sensory appreciation to light touch, deep touch, vibratory, pinprick, and temperature stimuli was reported as normal and symmetrical over both upper and both lower extremities. No sensory deficits or altered sensations were

reported, especially over the arms and over the hands and all the fingers and both thumbs.

The muscle strength in both upper and lower extremities, initially, could not be reliably assessed because of her complaints of severe pain even when contracting those major muscle groups against their own weight; however, no regional atrophies were noted. Quite the contrary, the muscle development noted in all the extremities was symmetrical and no regional atrophies were noted. In order to quantitatively assess the muscle mass of both upper extremities, circumferences at homologous levels were obtained at the level of the axilla and also in reference to the lateral epicondyle of the humerus and the following measurements were noted:

	*Right	Left
Axillary	14 3/8"	14 1/4"
4" Above	10 1/4"	10"
4" Below	9 3/8"	8 3/4"

*The slight increase in the muscle mass present in the right, dominant upper extremity at all three levels is a reflection of the patient's right-hand dominance. This increase is within normal limits and is considered a normal physiological adaptation whereby the dominant extremity handles the more difficult and heavier tasks, and the more dextrous tasks. This, as you can see, is the case with Mrs Cintron.

Upon initially assessing the handgrip strength in a direct manner she reported severe pain in both arms while attempting to apply even the most minimal force to the Jamar dynamometer. After much verbal encouragement, however, she started to increase the tension to the point where the following three highest values of force were recorded by the

dynanometer in pounds while in the second adjustment position:

RIGHT HANDGRIP: 78, 70, 65 pounds
LEFT HANDGRIP: 75, 60, 55 pounds

On attempting to measure the mobility of the major joints of the upper extremity, once again, Mrs. Cintron's initial reaction was her statement regarding her inability to move the shoulders, elbows, and wrists in the prescribed directions as those motions produced significant and severe pain. However, after much verbal encouragement and after much convincing, she would move the body parts, allowing for the following quantitative measurements to be taken using a dual inclinometer system according to the American Medical Association's standards:

Shoulders:	Right	Left
Flexion	0 to 165	0 to 170
Abduction	0 to 165	0 to 170
External Rotation	0 to 90	0 to 85
Internal Rotation	0 to 70	0 to 70
Elbows:	Right	Left
Flexion	0 to 150	0 to 150
Pronation	0 to 85	0 to 90
Supination	0 to 90	0 to 90
Wrists:	Right	Left
Dorsiflexion	0 to 80	0 to 80
Volar flexion	0 to 80	0 to 80
Ulnar Deviation	0 to 30	0 to 30
Radial Deviation	0 to 15	0 to 15

The mobility of the lumbar region was quantitatively measured in a similar manner, again, according to the

specific protocol established by the American Medical Association using a dual inclinometer system. The following values of lumbar mobility were recorded in degrees as follows:

Lumbar Flexion	0 to 62 degrees
Lumbar Extension	0 to 22 degrees
Lumbar R Lateral Flexion	0 to 27 degrees
Lumbar L Lateral Flexion	0 to 23 degrees

The straight leg raising maneuver was performed in an unrestricted and pain-free manner up to 85 degrees bilaterally without producing any complaints of pain nor radicular-type symptoms into the buttocks or lower extremities. This measurement was obtained using a goniometer.

The leg length measured 33 1/2" bilaterally when measured from the anterior superior spine to the medial malleoli.

Initially, attempting the most inconsequential touch over the entire lumbar paraspinous muscle mass elicited complaints of severe and unbearable pain, along with a rather violent contraction of the paraspinous muscles, along with multiple facial expressions. In response to questions as to whether there was any area in the trunk from the neck down to the buttocks that would not hurt in response to the most gentle touch using a piece of cotton gauze and the rubber tubing of a stethoscope, Mrs. Cintron mentioned that the entire region of the upper, middle and low back region was acutely painful. In order to assess the degree of volition in her responses, a rubber padded transducer with an area measuring 0.75 square inches connected to a Chatillon dynamometer was used to test homologous areas of the upper, middle, and lower cervical, thoracic, and lumbar paraspinous muscle masses. In that manner, progressive

amounts of pressure were gradually exerted. Mrs. Cintron was instructed to alert this examiner at the time when the pressure produced by the transducer pad became unbearable to her. The results of this algometry test (pain measurement) are expressed below in the number of pounds of force needed to produce unbearable pain, as reported by the patient:

ALGOMETRY TEST

Muscle Mass	Right	Left
Upper Lumbar	2.0 pounds	0.5 pounds
Middle Lumbar	2.5 pounds	1.0 pounds
Lower Lumbar	1.5 pounds	1.0 pounds
Upper Thoracic	1.5 pounds	0.5 pounds
Middle Thoracic	2.0 pounds	1.5 pounds
Lower Thoracic	1.0 pounds	1.5 pounds
Upper Cervical	0.5 pounds	0.5 pounds
Middle Cervical	1.0 pounds	0.5 pounds
Lower Cervical	0.5 pounds	0.5 pounds

The three major regions of the back were then examined simultaneously with other non-related areas while diverting her attention to the latter. In that manner, no pain was reported in any area. No spasms were demonstrable. There were no areas of tightness or tenderness, nor was there any palpable fibrosis.

When the lumbar region was examined in that manner, no complaints of discomfort were reported whatsoever. As mentioned, no spasms were demonstrable over the lower, mid and upper paralumbar muscles, over the multisidi, over the sacrospinalis, or over the musculotendinous junction of the erector spinae.

The gluteal region was similarly examined and, again, no pain was reported. The gluteal musculature was well-

developed, soft, non-tender, and free of acute spasm to deep palpation and prolonged pressure. Both right and left sacroiliac joint regions and sciatic notches were similarly non-tender to deep pressure. Pressure over the sciatic nerves along the posterior aspect of both thighs also failed to produce any discomfort.

Similarly, the cervical, shoulder girdle, parathoracic, and parascapular muscle groups were well-developed, easily palpable, non-tender, and free of active spasms or fibrositic nodules to the deepest and vigorous palpation. Both right and left paracervical, suboccipital, scaleni, sternocleidomastoid, levator scapula, and upper and lower trapezius muscle groups were well- developed and soft to palpation. In the shoulder girdle regions, both right and left supraspinatus and infraspinatus and teres major and minor, and rhomboid muscle groups were similarly soft and non-tender to direct palpation.

Palpation over the upper extremities elicited similar complaints of acute pain, mostly in the right side. When both arms were palpated simultaneously, however, while diverting her attention to the left upper extremity, Mrs. Cintron complained of some generalized tenderness in the left arm during simultaneous palpation over the major arm muscles of the right upper extremity including the deltoid, the biceps, the triceps, and over the tendinous origin of the forearm muscles and over the medial and lateral epicondylar regions. No complaints of pain in the right upper extremity were reported, however, when examined in this manner.

Compression and distraction maneuvers to both shoulder joints with the arms held in the anatomical position did not increase her symptoms.

Palpation over both forearms and especially over the dorsum of the wrists elicited multiple complaints of pain. In view of this, simultaneous palpation over both forearms while diverting her attention to the left forearm allowed this examiner to palpate quite deeply and in detail the right forearm and wrist.

In that manner, no complaints of any discomfort whatsoever were reported in the right forearm. Conversely, simultaneous palpation of both forearms while diverting her attention to the right forearm elicited no complaints of pain in the left forearm even though palpation over the left forearm was performed quite vigorously. The gliding motions of the flexor tendons of the distal forearms were normal. There was no evidence of any catching or clicking.

Examination of both hands, fingers, and thumbs elicited normal findings. The motions of the finger and thumb joints were unrestricted and pain-free. The opposition of each thumb was adequate, and there was no evidence of any joint effusion. The color of the skin over both hands was within normal limits and symmetrical. There was no evidence of swelling or joint effusion present.

The radial pulse was normal and equal bilaterally when assessed with each upper extremity held in the anatomical position, as well as in a position of maximal medical elevation. There was no evidence of threadiness, nor diminished pulse, no tingling sensation or other altered sensation, nor change in temperature in the hand, nor any discoloration of the skin especially while holding the right arm and then the left arm in the overhead position for an extended period of time.

Once again, the motor, sensory, and reflex functions of both upper extremities were tested. There was normal

sensation in both forearms and in both hands. No sensory deficits or disturbances were identified on repeated trials. No weakness was noted in the intrinsic muscles of the hand or in the forearm musculature.

The Tinel's sign was negative at the level of both wrists and both elbows (forceful tapping over the median and ulnar nerves). Those maneuvers failed to produce any radicular symptoms nor any discomfort or hypersensitivity at all. Palpation of the ulnar nerve at the ulnar canal immediately posterior to the medial epicondyle did not produce any pain in either the right or left side. Carpal compression failed to produce any pain. In fact, gentle tapping over the volar and dorsal aspects of the wrists elicited severe pain over the dorsal aspect of the wrists while no pain was elicited on tapping over the volar aspect. The Phalen's test was also negative bilaterally, as was the reverse Phalen's test.

Using a Chatillon strength dynamometer, the muscle strength of eight major action muscle groups of both upper extremities was quantitatively measured in pounds of force. These measurements were obtained at the point of maximal mechanical advantage for each muscle action tested by placing the rubber transducer pad of the dynamometer over the distal portion of the bone directly affected by the muscles tested:

Muscle	Right	Left
Shoulder Flexors	29.5 pounds	28.5 pounds
Shoulder Extensors	25.0 pounds	27.0 pounds
Shoulder Abductors	23.0 pounds	25.0 pounds
Shoulder Adductors	30.0 pounds	30.0 pounds
Elbow Flexors	27.5 pounds	30.0 pounds
Elbow Extensors	29.5 pounds	25.5 pounds

Wrist Dorsiflexors	16.0 pounds	16.0 pounds
Wrist Volar flexors	16.5 pounds	18.0 pounds

These values are judged to be within normal limits. Her efforts and inter-trial consistency were judged the be maximal. No complaints of pain were reported during that test.

Palpation over both legs elicited mild generalized tenderness over all the major muscle groups of both upper and lower extremities. When examined simultaneously while diverting her attention to other non-related areas, however, the major muscle groups of both lower extremities could be palpated quite deeply without any eliciting any complaints of pain whatsoever. There was normal muscle mass development noted with no areas of acute tightnes, tenderness, nor any swelling detected.

There was normal weight-bearing function of both lower extremities. The function of both hips, elbows, and ankles was within normal limits and pain-free in all planes.

The muscle mass of the lower extremities was quantitatively measured and the circumferences at three homologous levels were obtained in reference to the adductor tubercle of the medial femoral condyle. The values obtained were as follows:

	Right	Left
6" Above	19 1/4"	19 3/4"
3" Above	16 1/4"	16 1/2"
6" Below	14 1/2"	14 7/8"

The circumferences of both knees were within normal limits and virtually symmetrical bilaterally. There was no evidence of any anteroposterior or mediolateral laxity detected. The McMurray's test and drawer sign were

negative bilaterally. No crepitus was audible. There was normal patellar tracking. No evidence of any periarticular thickening was noted, either.

The motor, reflex, and sensory examinations of both lower extremities was again repeated and was found to be within normal limits. There were no lateralizing signs detected.

These findings were confirmed; being demonstrable when examined in both a direct and indirect manner. At this point the examination was concluded.

I have reviewed all the documents you have sent me in connection with Mrs. Cintron-Parrilla. Those include a check-list form document from Dr. Tomas Hernadnez, neurologist. That practitioner's original note dates back to September 11, 1995. There are some notations in the history portion of the form where the only notation in the neurological examination is the fact that Mrs. Cintron-Parrilla weighed 159 pounds and was 63 inches in height. There is no other notation made under the physical examination. At that time Dr. Hernandez' impression was notated as cerebral contusion and the fact that an EEG was performed and appeared to be within normal limits.

Based on these documents made available to me, it appears that Dr. Hernandez saw Mrs. Cintron-Parrilla on September 11, 1995; September 14, 1995; September 25, 1995; and October 23, 1995. Those visits appear to be related to the episode in her history of being "unconscious". No specific diagnosis was mentioned in those documents. It appears that, according to Dr. Hernandez, the MRI performed on September 21, 1995, was negative.

The next entry was on June 10, 1997. At that time Dr. Hernandez mentioned the pain in the arm as being sudden in

nature, even though there is no mention about her occupational duties. By June 21, 1997, he refers her to the state insurance fund. Dr. Hernandez mentioned some "T.O.S." (thoracic outlet syndrome) even though there were no documented findings to support a diagnosis.

These documents also include some tracings of a somato-sensory evoked potential study presumably performed by Dr. Hernandez. Very little can be commented about this study since there is no proper labeling of these studies. We don't even know which specific structures were being studied, which nerves were sampled, the placement of electrodes, etc... Not knowing what these curves represent, it is impossible to make any judgement. However, it should be noted that when homologous numbers are compared in terms of stimulus, intervals, amplitudes, and areas, that the difference between the two sides noted is, at times, less than one millisecond, and other times with a difference of less than a fraction of a microvolt in amplitude.

Despite the lack of any physical findings in his brief examination, and these insignificant differences in the values of the curves of the somato-sensory evoked potential study, it is most surprising to this examiner to see that Dr. Hernandez diagnosed her condition as a thoracic outlet syndrome. It is even more surprising to see that he referred her to El Fondo with a bilateral thoracic outlet syndrome, along with pain in the back when pain in the back is not one of the clinical features of a thoracic outlet syndrome. The biggest quantum leap is noticed when he refers all these "diagnoses" to her work in the absence of specific physical findings consistent with the diagnosis of thoracic outlet syndrome. I would give no validity to these statements.

As you very well know, there are specific clinical findings and hallmarks which are pathognomonic of the condition of thoracic outlet syndrome, none of which have ever been demonstrated in Mrs. Cintron-Parrilla's case, nor by her physician, nor by the physiatrist who saw her, and nor by this examiner.

The documents you provided me with also include a copy of an evaluation performed by either Dr. Lugo-Emanuelli, or Dr. Garcia, physiatrist. They obtain a history of pain in the extremities which apparently she referred to the febrile and diarrhea episode of February 1997. The physical findings that physiatrist elicited were essentially similar to the ones I elicited except for the presence of tenderness and spasms in the cervical region, in the lumbosacral region, and a positive Tinel sign on the right side at the time when they examined her on June 2, 1997. The rest of their physical examination was normal. Notice that the Phalen test, the Addsen test, and the complete neurological examination was negative.

The laboratories studies, the anti-nuclear antibodies, the complete blood chemistry and thyroid studies proved to be negative. A complete hematological urinalysis and microscopic urinalysis studies were negative. X-rays of the cervical and lumbosacral spines were negative, too. Radiological renal studies were similarly negative. The lumbar spine and chest MRI (in an attempt to show the thoracic outlet structures) proved completely negative.

From the history it appears that this 41-year old woman, a regulatory compliance officer, claims she sustained onset of pain with sensation of loss of strength in the right arm three months ago in May 1997 while shopping and reaching for an elevated object. Initially she was seen by a physiatrist who diagnosed her condition as "spasms in the neck". She

continued working into June 1997, however, she claims her symptoms expanded to include pain in both arms and especially both elbows, both hands, with pain to the neck and even into the upper and lower back regions, along with numbness into the thighs, calves, and toes. Mrs. Cintron-Parrilla decided to remain out of work as of June 18, 1997, due to her multiplicity of complaints.

The results of this examination are completely negative. This examination failed to show a single piece of clinical evidence in support of any systemic, regional or generalized musculoskeletal condition in this woman. Quite the contrary, the results of this examination showed normal musculoskeletal function in the upper and lower extremities, normal strength in the especially in the upper extremities, normal mobility of all the major muscle joints of the extremities and of the entire axial region, as well as intact peripheral neurological function.

Notice that since the diagnosis of thoracic outlet syndrome was mentioned, a careful neurological and neurovascular examination of the upper extremities was repeated on several occasions and in several different ways less familar to the patient. The results were entirely negative.

Based on all those findings, in my medical opinion, this woman is not impaired from performing all her regular occupational duties. In my medical opinion, if she had some cervical myositis back in June at the time when she was seen by the physiatrist, then there has been a complete resolution of those symptoms and signs.

Her work station should perhaps be studied and, if necessary, modified in order for her to have a more suitable, ergonomic work station, if her description of her original work station is indeed accurate. As you know, one of my

associates, Ms. Flavia Bayron, is a master's degree level physical therapist who has extensive experience in work station analysis. Should you need those services, we will be more than glad to refer this situation for her evaluation and recommendation.

In summary, in my medical opinion, there are no physical reasons to preclude Mrs. Cintron-Parrilla from performing the typical duties of a regulatory compliance officer on a full-time basis as she described. She is in need of no medical nor surgical treatment at this time.

I trust I have answered your questions. Thank you for asking me to evaluate Mrs. Cintrón-Parrilla.

Sincerely yours,

/s/ Marcos U. Ramos
Marcos U. Ramos, MD
Medical Director

MUR/ehc
cintron.rec
rec

Exhibit III

Lilly
Lilly del Caribe, Inc.
PO Box 1198
Carolina P R 00986-1198
(787) 257-5555

2 de febrero de 1999
Sra. Kenia Cintrón
PO Box 232
Naguabo, Puerto Rico 00718-0232

Estimada señora Cintron:

Luego de nuestra reunión del pasado 11 de enero, procedí a verificar el historial de su reclamación de beneficios por incapacidad con nuestra compañía.

Entendíamos que usted regresaría a trabajar al finalizar su licencia por incapacidad a corta plazo. Durante el mes de mayo de 1998, informó al Departamento de Medicina Industrial por primera ocasión, que tenia intención de solicitar beneficios bajo nuestra política de Incapacidad Extendida (Extended Disability Leave). Aunque a primera impresión se le informo que posiblemente no cualificaría, se le solicito cierta información médica para cumplir con el procedimiento establecido, y se le citó para que regresara en dos semanas. Por el contrario, usted nunca regresó al Departamento de Medicina Industrial, no sometió los resultados médicos requeridos, ni volvió a comunicarse con el Dr. Félix Matos.

Su solicitud del 11 de enero, sobre el procesamiento de beneficios de incapacidad largo plazo, luego de haber sido

dada de baja de la compañía, es tardía, por lo cual no puede ser procesada.

Espero haber podido aclarar cualquier duda.

Atentamente,

/s/ Ileana Rivera
Recursos Humanos
cacr

(Certified Translation)[1] Exhibit III

Lilly
Lilly del Caribe, Inc.
PO Box 1198 Carolina, PR 00986-1198
(787)257-5555

February 2, 1999
Mrs. Kenia Cintron
PO Box 232
Naguabo, Puerto Rico 00718-0232

Dear Mrs. Cintron:

After our meeting on this past January 11th, I proceeded to verify the history of your claim for disability benefits with our company.

It was our understanding that you would return to work at the end of your short-term disability leave. During the month of May 1998, you informed the Industrial Medicine Department for the first time that you intended to request benefits under our policy of Extended Disability Leave. Although under our first impression you were informed that you may not qualify, certain medical information was requested from you so as to comply with established procedures, and you were given an appointment to return in two weeks. On the contrary, you never returned to the Industrial Medicine Department, you did not submit the required medical results, nor did you contact Dr. Félix Matos again.

---

[1] This certified translation is filed in the District Court, Docket Number 11 and identified as Exhibit 10

Your request of January 11 in connection with processing long-term disability benefits, after you had been released from the company, is late, therefore it cannot be processed.

I hope I have been able to clarify any doubts.

Sincerely,

(Signed: Illegible)
Ileana Rivera, Director
Human Resources
cacr

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO
- CERTIFIED –
To be a correct translation
prepared and/or submitted
for certification.
/s/ Edie Núnez 4/16/99
Edie Núnez
Certified Court Interpreter
Administrative Office
of the United States Court

APPENDIX BC

www.lilly.com **Lilly**

Eli Lilly and Company
Lilly Corporate Center
Indianapolis, Indianan 46285
U.S.A.

Phone 317 276 2000

August 25, 2003

BY FAX (787-874-0025) AND REGULAR MAIL

Ms. Kenia Cintrón
P.O. Box 388
Naguabo, Puerto Rico 00718-0388

Dear Ms. Cintron:

This is to confirm our telephone conversation on Friday, August 22, 2003, in which we discussed the possibility that Eli Lilly and Company Employee Benefits Committee ("Committee") would extend the ninety (90) day review period provided in Section 6.05(b) of the Plan fro the Committee to decide your appeal, for an additional thirty (30) days, Up to and including September 26, 2003. Consequently, this proposal would also amend paragraph nine (9) of the Agreement executed by the parties on August 14, 2002 ("Agreement").

As describe in the Committee's July 3, 2003, correspondence to you, the Committee requested (as did the Benefit Plan Review Committee before it) that you see a neurologist and a psychiatrist so that the Committee could further evaluate your claim for disability benefits. In response, you claimed that the Committee was modifying the

Plan's requirements and questioned the Committee's authority to request an independent medical evaluation. Moreover, you indicated in your July 16 correspondence that you would not comply with the Committee's request without imposing additional conditions (e.g. requiring a medical questionnaire for your physicians). Last Friday, you confirmed that you had not seen any of the physicians outlined in the Committee's July 3 correspondence. You did, however indicate, your willingness now to see such physicians as long as you did not have to choose them. While you previously indicated willingness to the Benefit Plan Review Committee to see physicians if it choose them and later failed to attend scheduled appointments with the selected physicians, the Committee is willing to agree to your request. Because of the Committee's requirement to respond to your appeal within the timeframe stated in the Agreement, however, it is not possible for you now to attend physician appointments without extending the stated deadline in the Agreement.

While the committee believes that it is in the mutual interest of the parties for you to attend an independent medical evaluation by both a neurologist and a psychiatrist, so that the Committee can further evaluate your claim, it is entirely your decision. Therefore, should you wish to attend the physician evaluations, you must return this letter to us by fax at (317) 433-8295 with your signature on or before noon (12:00p.m.) tomorrow, August 26, 2003, Should we received your written consent within the period provided, you would received a written communication from the Committee indicating the two physicians you must see and the dates for each evaluation., which would be at Lilly's expense.

If you continue to refuse to undergo the requested examinations, the Committee will be required to review your appeal without such information and may deny your requested based on you failure to comply with the terms of the plan or because it lacks necessary information to confirm your claimed disability.

Please let me know if you have any questions.

Sincerely,

Employee Benefits Committee

/s/ Charles A. Grandy
Charles A. Grandy

cc: Jesús Hernández Sánchez

I, Kenia Cintrón fully understand the meaning and extent of all the terms and obligations included in this letter, and I voluntarily and freely accept the same.

In Naguabo, Puerto Rico, this __ day of August 2003.

_____

Kenia Cintrón

APPENDIX BD

Certified Letter: 7002 0860 0008 6598 1637
Fax Numbers: (317) 433-6610
(317) 433-8295

August 25, 2003

To: Charles A. Grandy
Eli Lilly and Company
Employee Benefits Committee
Lilly Corporate Center
Indianapolis, IN 46285-1773
Tel. (317) 433-2607
Fax. (317) 433-6610

Cc: John J. Purcell
Eli Lilly and Company
Employee Benefits Committee
Lilly Corporate Center
Indianapolis, IN 46285-1773
Tel. (317) 433-3081
Fax. (317) 433-8295

Today, we received a letter dated August 25, 2003 (by fax) from the Employee Benefits Committee (the Committee) and signed by Mr. Charles A. Grandy. The Committee intent to certified this letter as an Amendment to the Agreement signed by the parties. In the second paragraph of such letter (or amendment), the Committee states allegations, which are not correct.

1- Kenia has never refused to undergo to a medical evaluation as stated on section 6.02 of the Employee Disability Benefit Plan (the Plan).

2- On July 16, 2003 letter, Kenia did not questioned the Committee authority. Kenia just reported the discrepancies between the Agreement, signed by the parties, and the Committee requests. Also, stated that she will undergo to medical evaluation as stated on section 6.02(b) of the Plan.

3- Kenia has never imposed to the Committee additional conditions in order to comply with the Committee's request to undergo to medical evaluations. Kenia just request a questionnaire in order to complete any information that could be missing, from the physicians that have been attending her, and she might not known that was missing. This request was because the Committee never told her what specific information was missing or was needed to be informed, in order to fulfill the Committee requirements. It is Kenia's right to request any information, documentation or paperwork that can help her to properly submit any information requested by the Committee.

4- On Friday (August 22, 2003) Kenia received a phone call by a person who identified himself as Mr. Charlie Grandy (while Mr. John Purcell is identified and stated as the contact person in the Agreement). In Friday's conversation, Kenia informed to Mr. Charlie Grandy that she had not seen the physicians listed by the Committee because the Committee never informed her of any appointment to undergo to any physician. Kenia answered that nobody has contacted her after the letter she sent on July 16, 2003. In the same conversation, Kenia confirmed to Mr. Charlie Grandy that she has always agreed to undergo to medical evaluations only as stated on section 6.02(b) of the plan, which Mr. Charlie Grandy now

agreed if she approves the 30 days extension period, extension which is out of Plan and out of the Agreement signed by the parties.

5- After the Friday's conversation, Kenia sent a letter by fax and certified mail informing that, she still able to undergo to the physicians evaluation as stated on section 6.02 of the plan and as signed by the parties under the Agreement.

Now, Kenia received this letter sent by the Committee threatening her to accept and amendment with information that is not correct. Moreover, the Committee tries to blame and frame Kenia if she does not agree to accept the amendment.

It is imperative that the Committee recognizes that:

1- Kenia submitted the appeal on time on May 29, 2003 by fax and Express Mail.

2- The Committee (Mr. John Purcell) certified that has received the appeal fax and letter, on the letter dated June 5, 2003, stamped on June 6, 2003 and received on June 12, 2003.

3- The Committee (Mr. John Purcell) sent a letter dated July 3, 2003, stamped on July 7, 2003 and received on July 14, 2003 (42 – 46 days later), in which, the Committee tried to change the terms and conditions of Agreement, signed by the parties. In this letter, the Committee never notified Kenia of any appointment with the physicians nor complied with section 6.02(b) of the Plan.

4- Kenia responded on July 16, 2003 (2 days after the arrival), that she would undergo to medical evaluations only as stated in section 6.02 (b) of the Plan and signed by the parties in the Agreement.

5- Mr. Charles A. Grandy called Kenia on August 22, 2003 (85 days later) requiring an amendment of an additional extension period of 30 days, extension that is out of the Plan and out of Agreement signed by the parties.

6- The Committee failed again to comply with the Agreement by never contacted nor informed Kenia of any appointment with the physicians within the period agreed and signed by the parties. Neither expressed any concern nor requested any clarification regarding Kenia's letter dated July 16, 2003 until today (August 25, 2003).

It is important to state that the Committee cannot threaten, blame or frame Kenia for its fault. Kenia has been properly complying with the Agreement as signed by the parties. It is the Committee responsibility to comply with the Agreement as well. The Committee is who has been several times failing to comply with the Plan and the Agreement signed by the parties. It is also very important to state that Kenia has never refused to undergo to medical evaluations as stated in section 6.02(b) of the Plan and signed by the parties in the Agreement. Kenia still willing to undergo to medical evaluations as stated on sections 6.02(b) and 6.05(b) of the Plan and signed by the parties in the Agreement.

Based on the fact that:

1- The stated information in the letter (or amendment) dated August 25, 2003, is not correct;

2- There have been many misunderstanding between the parties;

3- The Committee has failed consistently and intentionally to comply with the Agreement, signed by the parties, trying to adversely affect Kenia's benefits;

4- The Committee has never shown to have any good faith in attend Kenia's claim fairly;

5- It is a shame how the Committee is requesting from Kenia to make a decision to accept and approve an Amendment with information that is not the correct one in less than 24 hours when, the Committee has not been capable to comply with the timeframe stated in the Agreement signed by the parties and also stated in their own Plan; and now is demanding and additional 30 days extension period.

6- We will not consent to allow anyone to threaten, blame or frame Kenia;

We have agreed that we will not approve the Amendment as written. Therefore, Kenia will continue to comply with the Agreement as stated and signed by the parties without any Amendment.

Respectfully,

/s/ Miguel A. García Méndez	/s/ Kenia M. Cintrón
Miguel A. García Méndez	Kenia M. Cintrón Parrilla

Number of pages including this cover sheet: 3

TRANSACTION REPORT

AUG-26-03 08:37 AM

FOR: KENIA M. CINTRON 8740025

SEND

DATE	START	RECEIVER	PAGES	TIME	NOTE
AUG-26	08:31 AM	13174336610	3	5'17"	OK

TRANSACTION REPORT

AUG-26-03 08:42 AM

FOR: KENIA M. CINTRON 8740025

SEND

DATE	START	RECEIVER	PAGES	TIME	NOTE
AUG-26	08:39 AM	13174338295	3	2'30"	OK

APPENDIX BE

www.lilly.com **Lilly**

Eli Lilly and Company
Lilly Corporate Center
Indianapolis, Indianan 46285
U.S.A.

Phone 317 276 2000

August 27, 2003

BY FAX (787-874-0025) AND REGULAR MAIL

Ms. Kenia Cintrón
P.O. Box 388
Naguabo, Puerto Rico 00718-0388

Dear Ms. Cintron:

At its August 25, 2003 meeting the Eli Lilly and Company Employee Committee (the "EBC") reviewed your appeal dated May 29, 2003 of the denial by the Benefits Plan Review Committee (the "Committee") of your request for monthly benefit under The Lilly Extended Disability Plan (the "Plan"). Based on the information provided to the EBC, the EBC (1) was unable to verify your claimed disability; and (2) determine that you failed to provide necessary information to support your entitlement to disability benefits as required by the Plan.

As you may be aware, the Plan is a self-funded employee welfare benefit plan. The Plan is a component plan of "The Lilly Employee Welfare Plan and is governed by federal regulation under The Employee Retirement Income Security Act of 1994 ("ERISA"). The Employee Benefits Committee

is appointed by the Eli Lilly and Company Board of Directors to review claims under and administer this Plan.

The EBC reviewed the information provided in your appeal. The EBC upheld the Committee's pervious determination that you are ineligible for Plan benefits. Section 6.02(a) of the plan requires that you submit proof of your entitlement to disability benefits including: 1) the date on which the Employee's disability commenced; 2) the cause of the Disability; 3) any available Objective Medial Evidence of the Disability; 4) the nature and extend of the Disability; 5) the name and address of the Licensed Physician who is providing the Employee with regular care; for your claimed disability. Subsection 2.01(a)(5) of the Plan in relevant part defines "Disability" as "the inability of an employee to engage for remuneration of profit, in any occupation commensurate with the Employee's education, training and experience, provided that the inability results from an illness or accidental bodily injury that requires the Employee to be under regular care of a Licensed Physician". In evaluating the claim for disability benefits, section 6.02(b) of the Plan authorizes the EBC to "require an Employee to undergo examinations by a Licensed Physician or vocational expert chosen by the Employee Benefits Committee to determine the extent of any illness or injury for which the Employee makes a claim under the Plan. The Employee Benefits Committee may require an Employee to undergo such examinations as often as reasonably necessary to determine whether the Employee remains Disabled."

Because the EBC was unable to verify your claimed disability, your request for benefits was denied. Based on the information provided, the EBC agree with the Committee's findings that there appear to be several areas of poor

correlation between your reported symptoms, including the severity of your symptoms, and the diagnostic studies you provided. Specifically, you have complained of severe upper arm pain, neck pain, and back pain for several years. The severity of your symptoms, however are poorly correlated with diagnostic studies performed, X-Rays, CT Scans, bone scans and Doppler flow studies suggest mild degenerative disc disease without significant flow obstruction or nerve root compression. Such findings are not inconsistent with mild symptoms and/or the aging process. In addition, an emotional disease component is suggested by some evaluators but the extent of the disease is unclear as well as what effective interviews have been offered and your compliance with such recommendations.

In addition, the EBC also denied your request for EDL benefits because you failed to provide information necessary to verify your claimed disability as requested. By letter dated September 23, 2002, you were requested to undergo an independent medical evaluation by both a. neurologist and a psychiatrist to assist the Committee in completing its ongoing evaluation. After initially agreeing to undergo such evaluations by letter dated October 21, 2002, you did not appear at scheduled appointments and notified Lilly that you would not undergo such independent medical evaluations by letter dated November 8, 2002. Subsequently, the EBC requested that you undergo an independent medical evaluation by both a neurologist and a psychiatrist by letter dated July 3, 2003. Last Friday you confirmed that you have not seen any of the physicians identified. Instead by a letter dated July 16, 2003, you claimed that the Committee was modifying the Plan's requirements and questioned the EBC's authority to request an independent medical evaluation and

indicated that you would not comply with the Committee's request without imposing additional conditions. Following your conversation last Friday in which you now indicated a willingness to the EBC's review to allow sufficient time for you to see physicians. By letter dated August 26, however, you rejected that opportunity. Accordingly , the EBC also must deny your request for benefits for failure to comply with the term of the Plan.

Sincerely,

Employee Benefits Committee

/s/ John J. Purcell
John J. Purcell

cc: Jesus Hernandez Sanchez

APPENDIX BF

Certified Mail Number: 7002 0860 0008 6604 7905
Fax: (317) 433-8295
(787) 725-1112

Naguabo, PR
September 25, 2003

To: John J. Purcell
Eli Lilly and Company
Employee Benefits Committee
Mail Drop Code 1773
Lilly Corporate Center
Indianapolis, IN 46285-1773
Tel. (317) 276-3081
Fax. (317) 433- 8295

Cc: Jesus Hernández Sánchez
First Bank Building
Suite 806-810
1519 Ponce de Leon Avenue
San Juan. PR 00909
Tel. (787) 722-5414
Fax. (787) 725-1112

Guillermo Macari

From: Kenia M. Cintrón Parrilla
P.O. Box 388
Naguabo, PR 0O718-0388

Re: Request of Information

This is to request from the Lilly Employee Benefits Committee copies of all the documentation in connection to Mrs. Kenia M. Cintron disability and appeal claim determinations and, the identification of any medical or vocational expert whose advice was obtained for such determinations. In addition, we request the meaning of the abbreviation "Lab. Reg."

If you have any doubt please, do not hesitate to contact us.

Respectfully,

/s/ Miguel A. García Méndez
Miguel A. García Méndez

/s/ Kenia M. Cintrón
Kenia M. Cintrón Parrilla

TRANSACTION REPORT

SEP-25-03 04:04 PM

FOR: KENIA M. CINTRON 8740025

SEND

DATE	START	RECEIVER	PAGES	TIME	NOTE
SEP-26	08:31 AM	13174338295	3	43"	OK

7002 0860 0008 6604 7905

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

OFFICIAL USE

Postage	$ .37
Certified Fee	2.30
Return Receipt Fee (Endorsement Required)	1.75
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 4.42

NAGUABO PR
Postmark Here
USPS

Sent To: John J. Purcell - Employee Benefits Commi[illegible]
Street, Apt. No.; or PO Box No.: Lilly Corporate Center
City, State, ZIP+4: Indianapolis, Indiana 46285

PS Form 3800, April 2002 — See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Eli Lilly and Company
Employee Benefits Committee
Attn. John J. Purcell
Mail Drop Code 1773
Lilly Corporate Center
Indianapolis, Indiana 46285

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X L. Haward ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 9/30/03

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7002 0860 0008 6604 7905

PS Form 3811, August 2001 Domestic Return Receipt 102595-02-M-1540

APPENDIX BG

Federal Rules of Appellate Procedure And First Circuit Local Rules

Rule 4. Appeal as of Right-When Taken

(a) Appeal in a Civil Case

(1) **Time for Filling a Notice of Appeal.**

(A) In a civil case, except as provided in Rules 4(a)(1)(B),4(a)(4), and 4(c), the notice of appeal required by Rule 3 must be filed with the district clerk within 30 days after the judgment or order appealed from is entered.

(B) When the United States or its officer or agency is a party, the notice of appeal may be filed by any party within 60 days after the judgment or order appealed from is entered.

(C) An appeal from an order granting or denying an application for a writ of error *coram nobis* is an appeal in a civil case for purposes of Rule 4(a).

(2) **Filing Before Entry of Judgment.** A notice of appeal filed after the court announces a decision or order – but before the entry of the judgment or order – is treated as filed on the date of and after the entry.

(3) **Multiple Appeals.** If one party timely files a notice of appeal, any other party may file a notice of appeal within 14 days after the date when the first notice was filed, or within the time otherwise prescribed by this Rule 4(a), whichever period ends later.

(4) **Effect of Motion on a Notice of Appeal.**

(A) If a party timely files in the district court any of the following motions under the Federal Rules of

civil procedures, the time to file an appeal runs for all the parties from the entry of the order disposing of the last such remaining motion:

(i) for judgment under Rule 50(b);

(ii) to amend or make additional factual findings under Rule 52(b), whether or not granting the motion would alter the judgment;

(iii) for attorney's fees under Rule 54 if the district court extends the time to appeal under Rule 58;

(iv) to alter or amend the judgment under Rule 59;

(v) for a new trial under Rule 59; or

(vi) for relief under Rule 60 if the motion is filed no later than 10 days after the judgment is entered.

Rule 10. The Record on Appeal

(a) Composition of the Record on Appeal. The following items constitute the record on appeal:

(1) the original papers and exhibits filed in the district court;

(2) the transcript of proceedings, if any; and

(3) a certified copy of the docket entries prepared by the district clerk.

(b) The Transcript of Proceedings.

(1) **Appellant's Duty to Order.** Within 10 days after filing the notice of appeal or entry of an order disposing of the last timely remaining motion of a type specified in Rule 4(a)(4)(A), whichever is later, the appellant must do either of the following:

(A) order from the reporter a transcript of such parts of the proceedings not already on file as the appellant considers necessary, subject to a local rule of the court of appeals and with the following qualifications:

(i) the order must be in writing;

(ii) if the cost of the transcript is to be paid by the United States under the Criminal Justice Act, the order must so state; and

(iii) the appellant must, within the same period, file a copy of the order with the district clerk; or

(B) file a certificate stating that no transcript will be ordered.

(2) **Unsupported Finding or Conclusion.** If the appellant intends to urge on appeal that a finding or conclusion is unsupported by the evidence or is contrary to the evidence, the appellant must include in the record a transcript of all evidence relevant to that finding or conclusion.

(3) **Partial Transcript.** Unless the entire transcript is ordered:

(A) the appellant must — within the 10 days provided in Rule 10(b)(1) — file a statement of the issues that the appellant intends to present on the appeal and must serve on the appellee a copy of both the order or certificate and the statement;

(B) if the appellee considers it necessary to have a transcript of other parts of the proceedings, the appellee must, within 10 days after the service of the order or certificate and the statement of the

issues, file and serve on the appellant designation of additional parts to be ordered; and

(C) unless within 10 days after service of that designation the appellant has ordered all such parts, and has so notified the appellee, the appellee may within the following 10 days either order the parts or move in the district court for an order requiring the appellant to do so.

(4) **Payment.** At the time of ordering, a party must make satisfactory arrangements with the reporter for paying the cost of the transcript.

(c) Statement of the Evidence When the Proceedings Were Not Recorded or When a Transcript Is Unavailable. If the transcript of a hearing or trial is unavailable, the appellant may prepare a statement of the evidence or proceedings from the best available means, including the appellant's recollection.

The statement must be served on the appellee, who may serve objections or proposed amendments within 10 days after being served. The statement and any objections or proposed amendments must then be submitted to the district court for settlement and approval. As settled and approved, the statement must be included by the district clerk in the record on appeal.

(d) Agreed Statement as the Record on Appeal. In place of the record on appeal as defined in Rule 10(a), the parties may prepare, sign, and submit to the district court a statement of the case showing how the issues presented by the appeal arose and were decided in the district court. The statement must set forth only those facts averred and proved or sought to be proved that are essential to the court's resolution of the issues. If the statement is

truthful, it — together with any additions that the district court may consider necessary to a full presentation of the issues on appeal — must be approved by the district court and must then be certified to the court of appeals as the record on appeal. The district clerk must then send it to the circuit clerk within the time provided by Rule 11. A copy of the agreed statement may be filed in place of the appendix required by Rule 30.

(e) Correction or Modification of the Record.

(1) If any difference arises about whether the record truly discloses what occurred in the district court, the difference must be submitted to and settled by that court and the record conformed accordingly.

(2) If anything material to either party is omitted from or misstated in the record by error or accident, the omission or misstatement may be corrected and a supplemental record may be certified and forwarded:

(A) on stipulation of the parties;

(B) by the district court before or after the record has been forwarded; or

(C) by the court of appeals.

(3) All other questions as to the form and content of the record must be presented to the court of appeals.

Rule 11. Forwarding the Record

(b) Duties of Reporter and District Clerk.

(1) **Reporter's Duty to Prepare and File a Transcript.** The reporter must prepare and file a transcript as follows:

(A) Upon receiving an order for a transcript, the reporter must enter at the foot of the order the date

of its receipt and the expected completion date and send a copy, so endorsed, to the circuit clerk.

(B) If the transcript cannot be completed within 30 days of the reporter's receipt of the order, the reporter may request the circuit clerk to grant additional time to complete it. The clerk must note on the docket the action taken and notify the parties.

(C) When a transcript is complete, the reporter must file it with the district clerk and notify the circuit clerk of the filing.

(D) If the reporter fails to file the transcript on time, the circuit clerk must notify the district judge and do whatever else the court of appeals directs.

Rule 26. Computing and extending Time

(a) Computing time. The following rules apply in computing any period of time specified in these rules or any local rule, court order, or applicable statute:

(1) Exclude the day of the act, event, or default that begins the period.

(2) Exclude intermediate Saturdays, Sundays, and legal holidays when the period is less than 11 days, unless stated in calendars days.

(3) Include the last day of the period unless it is a Saturday, Sunday, legal holiday, or – if the act to be done is filing a paper in court – a day on which the weather or other conditions make the clerk's office inaccessible.

(4) As used in this rule, "legal holiday" means New Year's Day, Martin Luther King, Jr.'s Birthday, Presidents' Day, Memorial Day, Independence Day,

Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, Christmas Day, and any other day declared a holiday by the President, Congress, or the state in which is located either the district court that rendered the challenged judgment or order, or the circuit clerk's principal office.

Local Rule 27. Motions

(a) Assent. Motions will not necessarily be allowed even though assented to.

(c) Summary Disposition At any time, on such notice as the court may order, on motion of appellee or sua sponte, the court may dismiss the appeal or other request for relief or affirm and enforce the judgment or order below if the court lacks jurisdiction, or if it shall clearly appear that no substantial question is presented. In the case of obvious error the court may, similarly, reverse. Motions for such relief should be promptly file when the occasion, appears, and must be accompanied by four copies of a memorandum or brief.

APPENDIX BH

Federal Rules of Civil Procedure

VII. Judgment

Rule 54. Judgments; Costs

(b) Judgment Upon Multiple Claims or Involving Multiple Parties.

When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment. In the absence of such determination and direction, any order or other form of decision, however designated, which adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties shall not terminate the action as to any of the claims or parties, and the order or other form of decision is subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties.

Rule 58. Entry of Judgment

(a) Separate Document

(1) Every judgment and amended judgment must be set forth on a separate document, but a separate document is not required for an order disposing of a motion:

(A) for judgment under Rule 50(b);

(B) to amend or make additional findings of fact under Rule 52(b);

(C) for attorney fees under Rule 54;

(D) for a new trial, or to alter or amend the judgment, under Rule 59; or

(E) for relief under Rule 60.

(b) Time of Entry.

Judgment is entered for purposes of these rules:

(1) if Rule 58(a)(1) does not require a separate document, when it is entered in the civil docket under Rule 79(a), and

(2) if Rule 58(a)(1) requires a separate document, when it is entered in the civil docket under Rule 79(a) and when the earlier of these events occurs:

(A) when it is set forth on a separate document, or

(B) when 150 days have run from entry in the civil docket under Rule 79(a).

(d) Request for Entry.

A party may request that judgment be set forth on a separate document as required by Rule 58(a)(1).

Rule 59. New trials; Amendment of Judgments

(e) Motion to Alter or Amend a Judgment.

Any motion to alter or amend a judgment shall be filed no later than 10 days after the entry of the judgment.

Rule 60. Relief from Judgment or Order

(a) Clerical Mistakes.

Clerical mistakes in judgments, orders or other parts of the record and errors therein arising from oversight or omission may be corrected by the court at any time of its own initiative or on the motion of any party and after

such notice, if any, as the court orders. During the pendency of an appeal, such mistakes may be so corrected before the appeal is docketed in the appellate court, and thereafter while the appeal is pending may be so corrected with leave of the appellate court.

(b) Mistakes; Inadvertence; Excusable Neglect; Newly Discovered Evidence; Fraud, Etc.

On motion and upon such terms as are just, the court may relieve a party or a party's legal representative from a final judgment, order, or proceeding for the following reasons: (1) mistake, inadvertence, surprise, or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59(b); (3) fraud (whether heretofore denominated intrinsic or extrinsic), misrepresentation, or other misconduct of an adverse party; (4) the judgment is void; (5) the judgment has been satisfied, released, or discharged, or a prior judgment upon which it is based has been reversed or otherwise vacated, or it is no longer equitable that the judgment should have prospective application; or (6) any other reason justifying relief from the operation of the judgment. The motion shall be made within a reasonable time, and for reasons (1), (2), and (3) not more than one year after the judgment, order, or proceeding was entered or taken. A motion under this subdivision (b) does not affect the finality of a judgment or suspend its operation. This rule does not limit the power of a court to entertain an independent action to relieve a party from a judgment, order, or proceeding, or to grant relief to a defendant not actually personally notified as provided in Title 28, U.S.C., § 1655, or to set aside a judgment for fraud upon

the court. Writs of coram nobis, coram vobis, audita querela, and bills of review and bills in the nature of a bill of review, are abolished, and the procedure for obtaining any relief from a judgment shall be by motion as prescribed in these rules or by an independent action.

Rule 79. Books and Records Kept by the Clerk and Entries Therein

(a) Civil Docket.

The clerk shall keep a book known as "civil docket" of such form and style as may be prescribed by the Director of the Administrative Office of the United States Courts with the approval of the Judicial Conference of the United States, and shall enter therein each civil action to which these rules are made applicable. Actions shall be assigned consecutive file numbers. The file number of each action shall be noted on the folio of the docket whereon the first entry of the action is made. All papers filed with the clerk, all process issued and returns made thereon, all appearances, orders, verdicts, and judgments shall be entered chronologically in the civil docket on the folio assigned to the action and shall be marked with its file number. These entries shall be brief but shall show the nature of each paper filed or writ issued and the substance of each order or judgment of the court and of the returns showing execution of process. The entry of an order or judgment shall show the date the entry is made. When in an action trial by jury has been properly demanded or ordered the clerk shall enter the word "jury" on the folio assigned to that action.

(b) Civil Judgments and Orders.

The clerk shall keep, in such form and manner as the Director of the Administrative Office of the United States

Courts with the approval of the Judicial Conference of the United States may prescribe, a correct copy of every final judgment or appealable order, or order affecting title to or lien upon real or personal property, and any other order which the court may direct to be kept.

APPENDIX BJ

PART 2560: RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

Sec. 2560.503-1: Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if--

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of

paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a

claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)--

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference--

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section--

(1) (i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that--

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this

section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination.

(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be

furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph

(f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of--

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments--

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim

involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the

claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an

extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may

be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant --

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the

adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate

named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures--

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures--

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a

claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which--

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) Timing of notification of benefit determination on review.

(1) In general.

(i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later

than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims.

(A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph

(j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to

hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims.

(i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the

appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in

accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant--

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits--

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a

statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) Preemption of State law.

(1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2) (i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section **503** of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to

establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1) (i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations--

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term ``post-service claim'' means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term ``adverse benefit determination'' means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or ``notification'' means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term ``group health plan'' means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides ``medical care'' within the meaning of section 733(a) of the Act.

(7) The term ``health care professional'' means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to

the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Applicability dates.

(1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.